Printed: 05/20/2015 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIEI IDENTIFICATION NUM		CLIA		CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		175385		B. WING		C 05/20/2015		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR 200 SW NEWTO					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL RE DENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	S		F 000				
	The following citation complaint investigati	ns represent the finding on #86456.	s of					
	F 280 SS=D 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.		CP	F 280				
			n nding ility in needs, on of dent's					
	The facility reported 4 sampled for accide interview and record review and revise the use of positioning de	s not met as evidenced a census of 48 resident ents. Based on observative review, the facility faile e plan of care to include evices in bed for 2 of the #1 and #3) related to the	s with ion, d to the e 4					
	Findings included:							
	-	Order Sheet, dated 3/25						
LABORATOR	Y DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIV	E'S SIGNATURE		TITLE		(X6) DATE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLET	(X3) DATE SURVEY COMPLETED	
		175385		B. WING			C 0/2015
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	•	
ASBURY	PARK		200 SW NEWTO	14TH N, KS 6711	4		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RECENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 280	, 0			F 280			
	documented resident #1 re-admitted to the facility on 3/18/14.						
	The Significant Change Minimum Data Set (MDS), dated 4/28/15, documented the resident was rarely/never understood or made decisions and with severely impaired cognition per staff assessment. The resident required extensive assistance of 2 staff for bed mobility and was totally dependent on 2 staff for transfers, experienced one fall with a non-major injury since re-admission and bed rails were not used. The Care Area Assessment, dated 4/28/15, for Activities of Daily Living (ADLs) documented the resident returned to the facility on 4/22/15 and was admitted to hospice the same day. He/She is now actively dying, is bed bound and requires turning and repositioning routinely by nursing and hospice staff. The resident experienced a fall on 4/24/15 out of bed in which he/she obtained an abrasion. The resident is non-verbal and not able to make needs known due to the actively dying status.						
	The initial nursing assessment for Hospice, dated 4/22/15 at 5:57 PM, documented the resident readmitted to the facility from a short hospital stay on Hospice with comfort care. The resident is bed bound and required complete assistance with all ADL's. The care plan, dated 3/3/15 and updated on 3/20/14 for 1-2 staff to assist for bed mobility; updated on 5/14/14 for staff to provide frequent observation while the resident was in bed; updated on 3/6/15 to provide a floor mat beside the bed while the resident was in bed; update on 4/22/15 that the resident was admitted to hospice; and updated on 4/27/15 that hospice provided a						

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NAME OF PROVIDER OR SUPPLIER ASBURY PARK	ST	TREET ADDRES 200 SW 1 NEWTON				
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST BE PRI TAG OR LSC IDENTIFYIN	ECEDED BY FULL REGULA	_ATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 280 Continued From page 2 hi-low bed with ½ bed rails [mobility and a hospice mattrel lacked identification for use prior to the resident 's fall of 4/24/15. The nurse 's note, dated 4/24 documented the resident was a compromised position on knees on the mat beside the head of the bed, which was his/her head and neck held (transfer bar) used to enter at the right side of the bed. The reddened areas to the upper The Evaluation of Side Rail (13 days after the incident at of bed and side rails), docur recommendations "section rails/transfer bars are indicated for attempt to exit or does not less that the resident is immobile and documented that the resident is immobile and documented that the resident is indicated for further stated that the facility the use of these devices on re-admission of a resident to not re-assess the appropriate siderails/transfer bars when of the bed, the mattress, or siderail/transfer bar or if the had changed. On 5/13/15 at 12:32 PM, Lic C reported side rail/transfer	ress. The care plan of the transfer bar ut of the bed on 24/15 at 9:26 PM as observed by staff his/her hands and bed, toward the in low position with in place by the device and exit the bed on the resident had faint the chest. Usage, dated 5/7/15 and change of the stymented in the "at that no side at the bed after the which documented to the bed after the which documented the this resident. Staff ay had only assessed admission or to the facility and did teness or safety of the type of resident's condition consedered Nursing Staff are staff and the staff are staff as a change the type of resident's condition consedered Nursing Staff are staff and the staff are staff are staff as a change the type of resident's condition consedered Nursing Staff are staff as a change the type of resident's condition consedered Nursing Staff are staff as a change the type of resident's condition consedered Nursing Staff are staff as a change the type of resident's condition consedered Nursing Staff are staff as a change the type of resident's condition consedered Nursing Staff are staff as a change the type of resident's condition consedered Nursing Staff are staff as a change the type of resident staff are the type of resident staff as a change the type of resident staff are type of the type of type of the type of	f in ice 5 tyle d the che on	F 280			

NAME OF PROVIDER OR SUPPLIER ASBURY PARK SITEET ADDRESS, CITY, STATE, ZIP CODE 200 SW 14TH NEWTON, KS 67114 CALL DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION) DEFICIENCY ACT OR Addition DEFICIENCY	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
ASBURY PARK (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 280 Continued From page 3 done on admission, within the first 24 hours, and should be done again if there is a change in the resident's condition especially with mobility. Staff C stated they had never really been taught anything about these assessments, as far as how to use it to determine if the answers mean to use or not use the device. Staff C reported the assessment had an interventions section, with check box options that include one for if the resident will use the device or not, but that isn't always checked off by the nurses, even if the devices are used. The use of these devices should be identified on the care plan, in the mobility, safety or ADLs section. The facility failed to review and revise the plan of care to include the use of the transfer bar for this resident to ensure consistency of care. - The Physician's Order Sheet, dated 4/21/15, documented resident #3 admitted to the facility on			175385		B. WING			
NEWTON, KS 67114	NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		
F 280 Continued From page 3 done on admission, within the first 24 hours, and should be done again if there is a change in the resident 's condition especially with mobility. Staff C stated they had never really been taught anything about these assessments, as far as how to use it to determine if the answers mean to use or not use the device. Staff C reported the assessment had an interventions section, with check box options that include one for if the resident will use the device or not, but that isn't always checked off by the nurses, even if the devices are used. The use of these devices should be identified on the care plan, in the mobility, safety or ADLs section. The facility failed to review and revise the plan of care to include the use of the transfer bar for this resident #3 admitted to the facility on	ASBURY	PARK				4		
done on admission, within the first 24 hours, and should be done again if there is a change in the resident 's condition especially with mobility. Staff C stated they had never really been taught anything about these assessments, as far as how to use it to determine if the answers mean to use or not use the device. Staff C felt it was difficult to decipher that from the questions that are on the assessment. Staff C reported the assessment had an interventions section, with check box options that include one for if the resident will use the device or not, but that isn 't always checked off by the nurses, even if the devices are used. The use of these devices should be identified on the care plan, in the mobility, safety or ADLs section. The facility failed to review and revise the plan of care to include the use of the transfer bar for this resident to ensure consistency of care. - The Physician 's Order Sheet, dated 4/21/15, documented resident #3 admitted to the facility on	PRÉFIX	(EACH DEFICIENCY MUS	T BE PRECEDED BY FULL RE	GULATORY	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETION
The annual Minimum Data Set (MDS), dated 1/20/15, documented the residents Brief Interview for Mental Status (BIMS) score of 11, indicating moderately impaired cognition, required extensive assist of 1 staff for bed mobility and transfers and bed rails were not used. The Care Area Assessment for Activities of Daily Living (ADLs), dated 1/20/15, documented the resident required assist of limited to extensive assist, had a history of falls, a history of a stroke with right-sided effects, and impaired decision making.	F 280	done on admission, we should be done again resident 's condition of C stated they had never anything about these to use it to determine or not use the device decipher that from the assessment. Staff C or had an interventions soptions that include of the device or not, but off by the nurses, ever The use of these devite care plan, in the mesection. The facility failed to recare to include the use resident to ensure conductant of the device of the device of the care plan, in the mesection. The facility failed to recare to include the use resident to ensure conductant of the device of the device of the care plan, in the mesection. The facility failed to recare to include the use resident to ensure conductant of the device of the device of the care to include the use resident to ensure conductant of the care Area Asses Living (ADLs), dated resident required assist, had a history of with right-sided effect with right-sided effect.	within the first 24 hours, if there is a change in especially with mobility wer really been taught assessments, as far as if the answers mean to. Staff C felt it was diffice questions that are on reported the assessment with the form of the resident with that isn't always check on if the devices are used ices should be identified in obility, safety or ADLs eview and revise the place of the transfer bar form isstency of care. The company of the resident with the residents Brief Intervals admitted to the facility of the residents Brief Intervals of the res	the . Staff . Staff . Show o use cult to the int . Il use cked ed. d on an of r this /15, lity on d erview ting ensive s and Daily ne roke	F 280			

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F 280	The quarterly MDS, of the resident BIMS somoderately impaired changes from the present the resident required mobility and transfers bed when in bed and rail/transfer bar use. The Evaluation of Sid documented the resident had a history of finterventions section section of the assess. Observation of the resident bed and a hook style side of the bed with the against the wall. On 5/13/15 at 10:11 A reported the resident bed and required assin bed and to transfer cannot safely get in a is too forgetful to call. On 5/13/15 at 12:32 If C reported side rail a admission, within the be done again if there is condition especially they had never really the siderail/transfer bed how to use it to deter use or not use the definition and transfer to how to use it to deteruse or not use the definition and the definition of the residerail/transfer bed how to use it to deteruse or not use the definition and transfer to how to use it to deteruse or not use the definition and transfer bed how to use it to deteruse or not use the definition and transfer bed how to use it to deteruse or not use the definition and transfer bed how to use it to deteruse or not use the definition and transfer bed how to use it to deteruse or not use the definition and transfer bed how to use it to deteruse or not use the definition and transfer bed how to use it to deteruse or not use the definition and transfer bed how to use it to deteruse or not use the definition and transfer bed how to use it to deteruse or not use the definition and transfer bed how to use it to deteruse or not use the definition and transfer bed how to use it to deteruse or not use the definition and transfer bed how the use it to deteruse or not use the definition and transfer bed how the use it to deteruse or not use the definition and transfer bed how the use it to deteruse or not use the definition and transfer bed how the use it to deteruse the definition and transfer bed how the use of the transfer bed how the use of the transfer bed how the use of the transfer bed how	lated 4/14/15, documer ore of 09, indicating cognition and no other evious assessment. Indicated 4/21/15, document 1-2 staff assist for bed as, had a floor mat beside lacked identification of the Rail Usage, dated 4/2 dent preferred 2 side rails. The Nursing and recommendations	ented e the side 7/15, ils 15 at ow e exit the nove dent dently, sk. Staff on uld ident ' stated about as an to	F 280			

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AND PLAN OF	CORRECTION	IDENTIFICATION NUMBE	R:	A. BUILDING	i	COMPLET	ED C
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			NEWTO	N, KS 6711	4		
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F 280	Continued From page	e 5		F 280			
	are on the assessment. The use of these devices should be identified on the care plan, in the mobility, safety or ADLs section. On 5/13/15 at 3:12 PM, Direct Care Staff E reported the resident had a transfer bar and did not use the device to reposition when lying in the bed. Staff E stated the resident required 2 staff assist for mobility and transfers.						
	The facility failed to review and revise the plan of care to include the use of the transfer bar by this resident to ensure consistency of care.						
	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES		F 323				
	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.						
	The facility reported a 4 sampled for accider interview and record rensure 2 of the 4 resiremained free of accidimproper fitting of postbars) on their beds.	not met as evidenced be census of 48 residents ats. Based on observativeview, the facility failed dent's sampled (#1 and dents related to the itioning devices (transfer	s with on, I to #3)				
	•	rder Sheet, dated 3/25/ #1 re-admitted to the fa					

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ASBURY	PARK		200 SW		4	
			NEWIO	N, KS 6711		1 0/2
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F 323	The Significant Change (MDS), dated 4/28/15 was rarely/never under and with severely improved and with severely improved and with severely improved assessment. The resident sexperienced one fall of totally dependent on a experienced one fall of the Care Area Assess Activities of Daily Livit resident returned to the was admitted to hosp now actively dying, is turning and reposition hospice staff. The resident to make needs known status. The initial nursing asset/22/15 at 5:57 PM, or readmitted to the faction Hospice with comfound and required to ADL's. The care plan, dated 3/20/14 for 1-2 staff to updated on 5/14/14 for observation while the updated on 3/6/15 to the bed while the resident and updated on 4/27/hi-low bed with ½ bed mobility and a hospice with and updated on 4/27/hi-low bed with ½ bed mobility and a hospice	ge Minimum Data Set is, documented the resident cognition per stationary department of the provided required extensive for bed mobility and was 2 staff for transfers, with a non-major injury department of the provided rails were not used. Sment, dated 4/28/15, and (ADLs) documented the facility on 4/22/15 are itself the same day. He/Sident experienced a fail which he/she obtained in the provided resident is non-verbal and not in due to the actively dying sessment for Hospice, of the deciment of the provided resident is non-verbal and not in the provided assist for bed mobility from a short hospital fort care. The resident is complete assistance with a same day in bed; provide a floor mat besident was in bed; update ent was admitted to how the provided and the	ons ff e s since for I the nd She is s g and II on an : able ing dated ht all stay s bed h all /; ent side e on spice; ed a an	F 323		
	mobility and a hospic		II.			

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ASBURY	PARK		200 SW			
			NEWTO	N, KS 6711	4	
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F 323	Continued From page	e 7		F 323		
	prior to the resident 's fall out of the bed on 4/24/15.					
	1.		taff in ind id			
	_	d suffered from demen nt confused 100% of th on arrival to work at	II.			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 323	Continued From pag	e 8		F 323		
		would occasionally be	Ivina			
	at an angle in the bed, with feet dangling off the edge of the bed. The resident was in a low bed with a mat next to the bed on the floor and had a					
	hook style side rail (a	hand rail shaped like a	ın			
	upside down "U" th	nat is affixed to the bed				
	frame toward the hea	d of the bed used for				
	transfers and position	ning in bed) with an air				
	mattress on the bed.	Staff D recalled that the	9			
	resident did not use the bar independently, but would hold it during cares if staff cued the					
	resident to do so. Staff D stated the hook style					
	bars usually have lots of room between the bar					
	and the mattress, somewhere between 4-5					
	inches. After the resident slid out of the bed, on					
	4/22/15, facility staff changed out the bed and					
	transfer bar to a differ	-				
	_	In fact, it was so snug,				
		I lower the rail on the be				
	because it would rub	up against the air matti	ess.			
		PM, Licensed Nursing S				
	•	ansfer bar assessment vithin the first 24 hours,				
	·	n if there is a change in				
		especially with mobility				
		ver really been taught	. Stall			
		assessments, as far as	s how			
		if the answers mean to				
		. Staff C felt it was diffic				
		e questions that are on				
		reported the assessmen				
		section, with check box				
		ne for if the resident wi				
	•	that isn 't always chec				
		en if the devices are use				
		ices should be identifie				
	the care plan, in the r	nobility, safety or ADLs				
	section. Staff C was r					
	measurement that is	required to determine if	a			

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siderail measu for safe facility, not use depend the reshe/she his/her undate stated suppose. On 5/1 reporte staff for had a he/she on hos the development of the bed his/her. On 5/1 Staff A rail/tran comple whether use of found, and the too mu measu resider confirm on the consist he/she	ared the fit of the ety. When the rety. When the rety, he/she did not ethe transfer be dent on staff mesident did not not expected. Staff C reveal siderail/transhe/she could not have a did staff as the staff could in the resident or bed mobility a shook style hand a re-admitted to spice. Staff E storice independed, which was in a read was four staff as the device or not his/her head was eted by the staffer the resident of the device or not his/her head was eted by the staffer the resident of the much room. Staff urement of how and the siderail residents in the tently filled out the believed there	safe. Staff C had never be device and the mattre besident re-admitted to a move around much are ar. He/She was totally obility in bed. Staff C seed the device because a used them to turn viewed the resident 's fer bar assessment, and tell if the resident was evice or not. M. Direct Care Staff E was totally dependent and transfers. The resident transfers are the facility from the hoated the resident did not notly. The resident fell of the low position and and against the transfer land against the transfer land transfer was not dated of the resident's 1st side as ment was not dated of the facility appropriate to the low propriate of the low position and against the transfer land as found between the land tress because there	ess the and did tated e and as on 2 dent n spital ot use ut of bar. sing or was rail was the f ents J ating n with	F 323				

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F 323				F 323			
	The facility lacked a policy addressing the use of siderails/transfer bars.						
	The facility failed to thoroughly assess the appropriateness and safety for use of the transfer bar for this resident, who slid out of bed and whose head was found in the gap between the transfer bar and the mattress.						
	- The Physician's Order Sheet, dated 4/21/15, documented resident #3 admitted to the facility on 3/18/14. The annual Minimum Data Set (MDS), dated 1/20/15, documented the residents Brief Interview for Mental Status (BIMS) score of 11, indicating moderately impaired cognition, required extensive assist of 1 staff for bed mobility and transfers and bed rails were not used.						
	The Care Area Assessment for Activities of Daily Living (ADLs), dated 1/20/15, documented the resident required assist of limited to extensive assist, had a history of falls, a history of a stroke with right-sided effects, and impaired decision making.						
	the resident BIMS sco	cognition and no other	nted				
	the resident required mobility and transfers	odated 4/21/15, docume 1-2 staff assist for bed , had a floor mat beside lacked identification of	e the				
	The Evaluation of Sid	le Rail Usage, dated 4/	7/15,				

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NAME OF PROVIDER OR SUPPLIER ASBURY PARK		200 SW	ESS, CITY, STA 14TH N, KS 6711				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 323	documented the reside and had a history of finterventions section section of the assess. Observation of the re 9:02 AM, revealed the bed and a hook style side of the bed with the against the wall. At 10 the hand rail and the measured to be 5 1/2 with Administrative Nursin confirmed, at this time a maximum of 4 3/4 in was 3/4 of an inch less currently measured. On 5/13/15 at 10:11 A reported the resident bed and required ass in bed and to transfer cannot safely get in a is too forgetful to call. On 5/13/15 at 12:32 FC reported side rail as admission, within the be done again if there is condition especially they had never really the siderail/transfer be how to use it to determine on the assessment devices should be identicated and the mobility, safety or	dent preferred 2 side ra alls. The Nursing and recommendations ment were blank. sident's room, on 5/13/e resident with a high/lo side transfer bar on the he other side of the bed 1:48 AM, the space bet edge of the mattress we inches. This was confiursing Staff A and ag Staff B present. Staff e, the safe measuremenches for this space, we than the resident 's bear and out of bed independent of the point of	15 at ow e exit if ween as rmed fA nt is hich ed the nove dent dently, sk. Staff on uld ident ' stated about as an to nat in, in	F 323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
17538		175385		B. WING		C 05/20/2015	
NAME OF PROVIDER OR SUPPLIER				RESS, CITY, STA	TE, ZIP CODE		
ASBURY	PARK 		200 SW NEWTO	V 14TH ON, KS 67114			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGL OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 323	OR LSC IDENTIFYING INFORMATION)		r bar d the elp is a ently. did n the taff se of	F 323			